Initial Patient Information

Important: Complete this form as thoroughly as possible. Some questions may seem unrelated to your condition, but they may affect your diagnosis and treatment. All information is confidential.

Date	Full Legal Name				
Gender M F	Date of Birth	Age	Marital Status Single Married Separated Divorced		
Address			City	State	Zip
Daytime Phone # (home, work, cell – circle one) ( )			Alternate Phone # (home, work, cell – circle one) ( )		
Emergency Contact & Relationship			Phone Number of Emergency Contact Primary ( ) Alternate ( )		
Circle Health Insurance Coverage None PPO POS HMO Workers' Comp Auto Injury with MedPay Military Other _____					
E-mail _____ Promotional Information (such as Free Day) via e-mail? Yes / No May our acupuncturist discuss your private medical information with you via e-mail? Yes / No *** Please be aware that e-mail is not a secure communication and that discussion of your medical care will become part of your medical record.**					
Are you under the care of a physician? ☐ Yes ☐ No			For what conditions?		
Primary Care Doctor			Phone number	Specialty	
Other Doctors You See			Other Doctors You See		

Please describe your current health problems:

_____

How and When it began:

_____

Severity of the condition: 0 1 2 3 4 5 6 7 8 9 10

In the past week, how much has your problem interfered with your daily activities?
No interference 0 1 2 3 4 5 6 7 8 9 10 Unable to carry on any activities

How often are your symptoms present? ☐ Constantly ☐ Frequently ☐ Intermittently ☐ Occasionally

Are you currently taking any Medications/Vitamins/Supplements? Please list them: _____

_____

Describe the reason why you are taking them: _____

Comments: _____

FEMALES:

Form of birth control _____	Pregnant ☐ Yes ☐ No	☐ Clotting	☐ Hot flashes
Last period _____	Last PAP test _____	☐ Heavy bleeding	☐ Vaginal dryness
Age started menstrual cycle ____	Age stopped _____	☐ Vaginal discharge	☐ Other: _____
☐ Menstrual pain	☐ Water retention	No. Pregnancies _____	_____
☐ Low backache	☐ Mood changes	No. Vaginal Deliveries ____	No. Miscarriages _____
☐ Irregular	☐ Painful breast	No. Caesareans _____	No. Abortions _____

SYMPTOMS *Please check if applicable*

Body Temperature:
☐ Tend to feel hot
☐ Palms or soles of feet feel hot
☐ Hot flashes
☐ Feel hot in afternoons/evenings
☐ Tend to feel cold
☐ Cold hands and feet

Perspiration:
☐ Sweat easily
☐ Palms or feet sweaty
☐ Night sweats

Digestion:
☐ Heartburn
☐ Abdominal cramps or pain
☐ Bad breath
☐ Acid reflux
☐ Distended feeling in abdomen
☐ Nausea/vomit
☐ Gas
☐ Difficulties with fatty/oily foods
☐ Gallstones
☐ Stomach ulcer
☐ Sores on tongue or in mouth

Bowels:
☐ Constipation
☐ Laxative use (specify_____)
☐ Loose stools
☐ Diarrhea
☐ Blood in stools
☐ Hemorrhoids

Urination:
☐ Frequent urination
☐ Burning/painful urination
☐ Blood in urine
☐ Cloudy urine
☐ Bladder infection
☐ Kidney infection
☐ Incontinence

Sleep:
☐ Difficulty falling asleep
☐ Wake and can't fall back to sleep
☐ Sleep apnea
☐ Frequent waking
☐ Dream-disturbed or nightmares
☐ Do you take something to help you sleep? If so, what? _____

Emotions:
☐ Happy
☐ Easily Irritable/Angry
☐ Worry
☐ Sad/Depressed
☐ Indecisive
☐ Anxious
☐ Fearful
☐ Nervous
☐ Suicidal

Cardiovascular:
☐ High blood pressure
☐ Low blood pressure
☐ Palpitations
☐ Irregular heart beat
☐ Bruise easily
☐ Varicose veins
☐ History of anemia
☐ Numbness of extremities
☐ Edema
☐ Chest pain/tightness
☐ Left arm pain

Respiratory:
☐ Shortness of breath
☐ Asthma
☐ Wheezing
☐ Difficulty inhaling or exhaling
☐ Cough with blood
☐ Dry cough
☐ Bronchitis or pneumonia

Skin and Hair:
☐ Dry hair or skin
☐ Oily hair or skin
☐ Acne
☐ Rashes
☐ Itching
☐ Hair loss
☐ Slow healing wounds

Eyes / Ears / Throat / Mouth:
☐ TMJ syndrome
☐ Grinding teeth
☐ Bleeding gums
☐ Dry and/or scratchy throat
☐ Hoarseness
☐ Ringing in ears
☐ Ear infection/pain
☐ Hearing loss
☐ Recent blurry vision
☐ Glaucoma, cataracts or other: ____

Nose / Sinuses:
☐ Runny nose
☐ Nosebleed
☐ Rhinitis/sinusitis
☐ Loss of smell
☐ Sinus headache
☐ Hay fever/allergies

Headaches: _____

☐ Kidney stones	☐ Cough with phlegm

Medical History

□ AIDS/HIV	□ Hepatitis A/B/C	□ Scarlet Fever
□ Allergies (food, latex)	□ Herpes	□ Seasonal Allergies
□ Asthma	□ Joint Replacements	□ Seizures
□ Birth Trauma	□ Lyme's Disease	□ Sinus Infections
□ Cancer	□ Lymph Nodes Removed	□ Tuberculosis
□ Diabetes (type___)	□ Multiple Sclerosis	□ Operations
□ Emphysema	□ Pacemaker	□ Other _____
□ Fibromyalgia	□ Polio	
□ Heart Disease	□ Rheumatic Fever	

Family Medical History: (Please list any significant family illnesses, e.g. diabetes, heart disease, respiratory conditions, blood pressure, neurological disorders, psychological disorders, arthritis)

Mother:_____

Father:_____

Siblings: _____

Grandparents: _____

Please indicate if you use any of the following:

□ Coffee □ Soda pop □ Water □ Alcohol □ Recreational drugs □ Tobacco

Exercise, Energy and Dietary:

How much do you exercise per week?_____ Length of workout _____ Activities _____

How is your energy level?_____When is it lowest ?_____Highest?_____

How many meals per day do you eat?_____What foods are your weakness?_____Are you a vegetarian?_____

How much water do you drink per day_____ Prefer warm or cold drinks? _____Excessively thirsty?_____

I certify that the above information is complete and accurate to the best of my knowledge. If the health plan information is not accurate, or if I am not eligible to receive a health care benefit through this provider, I understand that I am liable for all charges for services. I agree to notify this provider immediately whenever I have changes in my health condition or health plan coverage. I understand that my provider of acupuncture services may need to contact my Primary Care Physician or treating physician if my condition needs to be co-managed. Therefore, I give authorization to my provider of acupuncture services to contact my medical doctor if necessary.

Patient Signature _____ Date _____